STATE OF ILLINOIS

Department of Financial and Professional Regulation
Division of Insurance

IN THE MATTER OF:

CHRISTIAN CARE MINISTRY
And
CHRISTIAN CARE MEDI-SHARE
And
ROBERT Y. BALDWIN
President, Christian Care Ministry
P. O. Box 120099
West Melbourne, Florida 32912-0099

HEARING NO. 07-HR-0266

AND/OR SUBSIDIARY OR
AFFILIATED COMPANIES

ORDER

I, Michael T. McRaith, Director of the Illinois Division of Insurance, hereby certify that I have read the entire Record in this matter and the hereto attached Findings of Fact, Conclusions of Law, and Recommendations of the Hearing Officer, Timothy M. Cena, appointed and designated pursuant to Section 402 of the Illinois Insurance Code (215 ILCS 5/402) to conduct a Hearing in the above-captioned matter. I have carefully considered and reviewed the entire Record of the Hearing and the Findings of Fact, Conclusions of law and Recommendations of the Hearing Officer attached hereto and made a part hereof.

I, Michael T. McRaith, Director of the Illinois Division of Insurance, being duly advised in the premises, do hereby adopt the Findings of Fact, Conclusions of Law and Recommendations of the Hearing Officer as my own, and based upon said Findings, Conclusions and Recommendations enter the following Order under the authority granted to me by Articles VII and XXIV of the Illinois Insurance Code (215 ILCS 5/121 et seq. and 5/401 et seq.) and Article X of the Illinois Administrative Procedure Act (5 ILCS 100/10-5 et seq.). In addition, my review of the facts presented in the hearing of this

matter establishes that the Respondent receives money from individual participants, pools that money with amounts received from other members, and places all of those receipts into a single trust fund under Respondent's control from which medical expenses and benefits are paid. This risk-pooling activity by the Respondent is further evidence that the Respondent is transacting the insurance business in this state.

This Order is a Final Administrative Decision pursuant to the Illinois Administrative Procedure Act (5 ILCS 100/1-1 et seq.). Further, this Order is appealable pursuant to the Illinois Administrative Review Law (735 ILCS 5/3-101 et seq.).

NOW IT IS THEREFORE ORDERED THAT:

1) The Respondent's Motion to Recuse is denied;

2) The Cease and Desist Order previously issued on March 19, 2007 in this matter, is made permanent; and

3) The Respondent, Christian Care Ministries, shall pay, within 35 days of the date of this Order, the sum of $1,737.50 as costs of this proceeding, directly to the Illinois Division of Insurance, Tax and Fiscal Services Unit, 320 W. Washington St., 4th Floor, Springfield, Illinois 62767.

DEPARTMENT OF FINANCIAL AND PROFESSSIONAL REGULATION of the State of Illinois;

DIVISION OF INSURANCE

Date: 6-1-7

Michael T. McRaith
Director

STATE OF ILLINOIS

Department of Financial and Professional Regulation
Division of Insurance

IN THE MATTER OF:

HEARING NO. 07-HR-0266

CHRISTIAN CARE MINISTRY;
CHRISTIAN CARE MEDI-SHARE; and
ROBERT Y. BALDWIN

FINDINGS OF FACT, CONCLUSIONS OF LAW AND RECOMMENDATIONS OF THE HEARING OFFICER

Now comes Timothy M. Cena, Hearing Officer in the above captioned matter and hereby offers his Findings of Fact, Conclusions of Law and Recommendations to the Director of Insurance.

FINDINGS OF FACT

PROCEDURAL DOCUMENTS AND THE EVIDENCE PRESENTED AT HEARING

1) On March 19, 2007, the Illinois Director of Insurance, Michael T. McRaith, (Director) issued an Order to Cease and Desist to Christian Care Ministry (CCM), Christian Care Medi-Share (CCMS) and Robert Y. Baldwin and subsidiary or affiliated companies (Respondents) (Hearing Officer Exhibit # 2). The Order to Cease and Desist was received by the Respondents at their address in West Melbourne, Florida (see the U.S.P.S. Domestic Return Receipt Card attached to Hearing Officer Exhibit # 2). The Order required the

Respondents to immediately cease and desist any and all practices involving Christian Care Medi-Share which allegedly purport to provide insurance benefits to the residents of the State of Illinois. The Order also contained a Notice of Hearing, as is required by Section 401.1 of the Illinois Insurance Code (215 ILCS 5/401.1), setting a Hearing date and location for evidence to be taken in this matter, on April 12, 2007 at the Offices of the Illinois Division of Insurance (Division) in Springfield, Illinois.

2) Joseph T. Clennon filed a Notice of Appearance as Counsel for the Division in this matter (Hearing Officer Exhibit # 2).

3) Timothy M. Cena was appointed as Hearing Officer in this matter by Order of the Director, dated March 19, 2007 (Hearing Officer Exhibit # 1).

4) On April 3, 2007, Kirk Petersen and Steve W. Kinion filed an Entry of Appearance on behalf of the Respondents (Hearing Officer Exhibit # 3).

5) On April 5, 2007, the Respondents filed Motions for Continuance and Discovery (Hearing Officer Exhibits # 4 and # 5).

6) On April 11, 2007, the Hearing Officer issued an Order granting the Respondents' Motions for Continuance and Discovery. The Hearing was continued until June 27, 2007 (Hearing Officer Exhibit # 6).

7) On April 5, 2007, the Respondent filed a Motion to Partially Stay the Order to Cease and Desist (Hearing Officer Exhibit # 7).

8) On April 12, 2007, the Division filed a Response Opposing the Motion to Partially Stay the Order to Cease and Desist (Hearing Officer Exhibit # 8).

9) On April 13, 2007, the Director issued a Order denying the Respondents' Motion to Partially Stay. The Director also in that Order rescinded the Hearing Officer's April 11, 2007 Order and set the matter for Hearing on April 20, 2007 (Hearing Officer Exhibit # 9).

10) On April 16, 2007, the Respondents filed a Motion for Continuance and Filing of Objections (Hearing Officer Exhibit # 10).

11) On April 16, 2007, the Director issued an Order granting the Motion for Continuance and continued the proceeding until May 3, 2007 (Hearing Officer Exhibit # 11).

12) On April 30, 2007, the Respondents filed an Answer and Affirmative Defenses in this matter (Hearing Officer Exhibit # 12).

13) The Hearing in this matter was convened on May 3, 2007, at 10:00 AM, at the Division's Offices in Springfield, Illinois at which time were present Timothy M. Cena, Hearing Officer; Joseph T. Clennon, on behalf of the Division; Steve Kinion, on behalf of the Respondents; and Robert Y. Baldwin, Respondent.

14) The evidence presented at the Hearing in this matter by the Division consisted of 26 pieces of documentary evidence. The evidence presented by the Division includes the following:

A) On September 6, 2005, in the Circuit Court of the Nineteenth Judicial Circuit, Lake County Illinois, in Case # 05 L 740, Plaintiff Georgeanna Guritz filed a Verified Complainant at Law alleging that the Defendant in that case, Christian Care Medi-Share, breached its contract to provide health care benefits to the Plaintiff. In Count II of the Complaint, the Plaintiff alleged vexatious and unreasonable

denial of claim in violation of Section 155 of the Illinois Insurance Code (215 ILCS 5/155). The Defendant filed a Motion to Dismiss Count II of the Complaint arguing that the Medi-Share program is not an insurance policy pursuant to which the Defendant was required to indemnify the Plaintiff.

The Court denied the Motion, stating that "although the Defendant's guidelines deny it offers insurance, the court finds the complaint if proved, would state a cause of action for vexatious denial of an insurance claim." In it's analysis the Court stated that "this Court finds it difficult to characterize Medi-Share as merely a needs sharing program." The Court cited Griffin Systems, Inc. v. Washburn, 153 Ill. App. 3d 113 (1st Dist. 1987) as the leading case in Illinois regarding the issue of what constitutes insurance. The Court discussed the four-prong test developed in Griffin and concluded that the facts of the case indicated that all four parts of the test had been satisfied.

The case, however, was dismissed prior to final adjudication, when the parties agreed to enter Mediation (see Division Exhibit # 1). Therefore, no final decision on the specific insurance question, outside of the Court's statements regarding the Motion to Dismiss, was had.

B) On March 21, 2007, the Oklahoma Insurance Department (OID) filed with the Insurance Commissioner of the State of Oklahoma (Commissioner) an Application for Emergency Cease and Desist Order alleging that CCMS, was pursuant to Oklahoma law, doing an insurance business in that State (see Division Exhibits # 2 and # 4). Attached to the Application as Exhibit B was a Decision from the District Court of Creek County,

State of Oklahoma, Bristow Division, in Case # B-CJ-2006-067, Bowman v. Medi-Share et. al. holding the CCMS was involved in the offering of contracts of insurance which were not exempt from regulation by the OID.

C) In February of 2006, Michael Rowden filed an action against CCMS in Montana's First Judicial District Court, Lewis and Clark County, Cause # BDV-2006-109, Michael Rowden v. American Evangelical Association et. al. alleging the Defendants' failure to pay insurance benefits owed to Rowden (see Division Exhibit # 3). In ruling on Rowden's Motion for Summary Judgment on the issue of whether, as a matter of law, that the Medi-Share program meets the definition of insurance in Montana, and that Medi-Share is an unauthorized insurer, the Court held that the Motion must be granted in that there is no genuine issue of material fact that Medi-Share is transacting the business of insurance in Montana.

The Court, in its ruling, referred to a South Dakota court decision in the Second Judicial District of South Dakota, Case # 04-492, S.D. 2006, Bosch v. Christian Care Medi-Share, in which it was held that Medi-Share is insurance as a matter of law.

D) On July 19, 1999, the State of Wisconsin, through its Insurance Director, entered into a Stipulation and Consent Order with CCMS in which it was agreed that CCMS would operate in compliance within the statutory requirements for exemption by Section 600.01 (1)(b) 9 of the Wisconsin Statutes (see Division Exhibit # 5). The Order, in part, required that CCMS provide a disclaimer to its members and applicants for membership in Wisconsin indicating that the program does not guarantee that a member's medical bills

will be paid and further, that the program should never be considered as a substitute for an insurance policy.

E) On April 4, 2003, the Commonwealth of Pennsylvania Insurance Department through its Director, issued a letter to CCMS indicating that the Department had discontinued its investigation of CCMS based upon written CCMS representations that modifications had been made to CCMS operations in Pennsylvania in light of the requirements of Section 1003 of the Insurance Department Act, 40 PS 23 (see Division Exhibit # 6). CCMS also agreed to remove all objectionable statements contained on it's website regarding the State of Pennsylvania. Section 40 PS 23 contains a disclaimer similar to the disclaimer referenced in 14 (D) above.

F) On January 18, 2007, in the Commonwealth of Kentucky, Franklin Circuit Court, Division 11, in Civil Action # 02-CI-00837, Commonwealth of Kentucky vs. E. John Runhold dba Christian Care Ministry and Medi-Share, the Court issued Findings of Fact, Conclusions of Law and Final Order holding that under Kentucky law "for an insurance agreement to be considered insurance, there must be is (sic) risk shifting" (see Division Exhibit # 7). The Court further held that as there is no risk shifting in the CCMS agreement, " it cannot be construed as a contract of Insurance" under Kentucky law. The Court further held that the CCMS program fits "squarely" within a Kentucky statute exempting religious groups from the requirements of the Kentucky Insurance Code.

G) The Division offered as evidence in this matter, and which were accepted into the Record by the Hearing Officer Division Exhibits # 10- # 17:

i) A 1/30/07 email from CCMS to Theresa Blash describing the CCMS healthcare program (Exhibit # 10);

ii) Thirteen pages of CCMS advertising published in various media (Exhibit # 11);

iii) A transcript of a CCMS radio commercial (Exhibit # 12);

iv) An Agency Agreement between the Lloyd Daniel Corporation and CCMS (Exhibit # 13);

v) A CCMS Marketing Audit Contract (Exhibit # 14);

vi) A five page description by a CCMS employee of the CCMS Needs Sharing Process (Exhibit # 15);

vii) A CCMS member information request (Exhibit # 16);

viii) A CCMS Need Report Form (Exhibit # 17).

H) On August 25, 2006, Carlson Frederick and Company, Certified Public Accountants presented to the Administrative Board of Elders of the American Evangelistic Association (the predecessor of CCMS) an Independent Auditors' Report, auditing the combined financial position of the American Evangelistic Association as of June 30, 2006 (see Division Exhibit 18);

I) In August 2006, Carlson Frederick and Company presented to the Trustees Group Major Medical Sharing Trust on behalf of Christian Ministries an Independent Auditor's Report auditing the financial

position of Group Major Medical Sharing Trust on behalf of Christian Ministries as of June 30, 2006 (Division Exhibit # 19);

J) On August 6, 1993, Christian Care Ministry (CCM) entered into a Letter of Agreement with Larry Gaskill in which the parties agreed that Gaskill would perform Third Party Administrator (TPA) duties on behalf of CCM (Division Exhibit # 20);

K) On June 19, 2006, CCM and Cypress Benefit Administrators (Cypress) entered into a Contract in which Cypress agreed to perform claims processing on behalf of CCM (Division Exhibit # 21);

L) On June 1, 2006, AEA International Inc. (AEAI) and Multi Plan Inc., a Preferred Provider Organization (PPO), entered into contract in which Multi-Plan Agreed to allow CCM access to Multi Plan's network of facility and health care providers (Division Exhibit # 22);

M) On May 7, 1997, CBA Administrative Services (CBA), a Third Party Administrator (TPA), and Beech Street Corporation (Beech) entered into a contract in which Beech agreed to allow CBA to access Beech's network of preferred provider (a discounted PPO rate program) (Division Exhibit # 23);

N) CCMS maintains and utilizes an 'underwriting manual', which purports to indicate the level of CCMS program coverage, or lack thereof, for various medical conditions (Division Exhibit # 24);

O) The Division of Insurance received multiple letters and email communications from Illinois citizens expressing concern over the

Division's decision to issue a Cease and Desist Order in this matter (Division Exhibit # 25);

P) On May 23, 2006, Respondent Robert Baldwin sent an email to Kevin Camilli explaining a new 'executive benefit' approved by the 'Executive Committee' on March 29, 2005 which waived all CCMS program pre-existing condition requirements for the members of the CCMS executive staff (Division's Exhibit # 26);

15) The evidence presented by the Respondents at the Hearing in this matter consisted of eight pieces of documentary evidence and the testimony of six witnesses. The documentary evidence presented by the Respondents includes the following:

A) The Affidavit of Harry Ramey, a member of the Illinois House of Representatives, attesting to a telephone conversation that the Affiant had with the Illinois Director of Insurance on or about April 13, 2007 regarding CCMS. The Respondents characterized the Affidavit as providing evidence of the Director's bias in this matter. The Hearing Officer declined to accept Respondents' Exhibit # 1 into the Record at the time it was offered, reserving a ruling until the preparation of this Report. The Hearing Officer concludes that the Exhibit is admissible and hereby enters it into the Record as Respondents Exhibit # 1;

B) CCMS provides to all of its prospective members a packet of materials, referred to by CCMS as Flight One, containing a cover letter to the prospective member, a Disclaimer Notice required by certain States to be presented to prospective members, and a CCMS Guidelines Booklet (Respondents Exhibit # 2);

C) The Respondents presented 28 Affidavits for consideration in this matter from Illinois resident members of CCMS. All of the Affiants attested to their satisfaction with the program, as well as, to their belief that CCMS was not required to pay or reimburse them for their medical expenses (Respondents Exhibit # 3);

D) Once an individual becomes a member of CCMS, that person receives in the mail a 'Welcome Packet' from CCMS (see Respondents Exhibit # 4). The Welcome Packet contains a document describing what is contained in the packet, a membership card, a welcome aboard guide, a copy of the Medi-share Program Guide, a quarterly newsletter, a 'Need Reporting From' and information on the Christian Disability Sharing Program;

E) The flow of member contributions to CCMS is illustrated by Respondents Exhibit # 5. The contributions are placed under the control of a Trust sitused in the British Bahamas. The actual contributions are placed in a bank account located in the State of Florida. Exhibit # 5 and companion testimony by Robert Baldwin, CCMS's President, indicate that 75% of the contributions are deposited into the Florida bank account for distribution to members while the remaining 25% is diverted to cover administrative fees, program expenses, and new member development;

F) On March 29, 2007, Respondent Baldwin received an email from Amy Comeens of Deland, Florida reporting that her back surgery was successful and thanking him for 'sharing' (Respondents Exhibit # 6);

G) Respondents Exhibit # 7 is the Curriculum Vitae of Frederic J. Jarrosz, an expert witness employed by CCM to testify in this matter.

H) Respondents Exhibit # 8 is a Homeward Bound Services Inc., Assisted Living Service Agreement. Homeward Bound was determined to be an unauthorized insurance company operating in Illinois;

16) Robert E. Carlson, a certified CPA with his own practice in the State of Florida, testified on behalf of the Respondents in this matter as follows (see Transcript, pgs. 85-128):

A) He has been a practicing CPA in Florida since 1968. He spent six years as a CPA with Peat Marwick & Mitchell and left that firm to become the Director of Accounting with Ryder Truck Rental for six years. He left Ryder to start his own firm in 1978 and has been on his own or in partnership with others ever since;

B) He has been auditing the financial statements of CCM since 1993. He is familiar with the terms ponsy or pyramid scheme which typically consist of an investment where the early investors receive a return on the investment only by bringing in additional investors to provide additional funding. The last-in investors are often left to receive no return on their investment because there are no new investors to feed the pyramid. In his opinion CCMS is not a ponsy or pyramid scheme because since 1993 CCMS has paid out $275,000,000.00 in needs. The Christian Care Ministry (CCM) is only the facilitator for this sharing ministry. CCM does not share with the needs of its members, rather only distributes the dollars of its members to other members in need;

C) Based upon his audit of the CCMS Trust in 2006 (see Division Exhibit # 19) he can state that there are no funds 'missing' from share dollars placed into the CCMS Trust Accounts (see Respondents Exhibit # 5);

D) Based upon his audit of CCM's predecessor AEAI Inc., as of 2006 (see Division Exhibit # 20) he can state that all monies that went into CCM for administrative costs have been accounted for;

E) The witness testified, although not being necessarily qualified as an expert in insurance transactions, that in his opinion CCM accepts no risk from its members and as such no insurance contract is formed;

F) The administer of the CCM Trust Fund and the Trust are located in the Bahamas. The Management Company for the Trust, as well as, the money shared by the members are located in the State of Florida;

G) The audited statement (Division Exhibit # 18) shows a decrease in cash of $10,000,000.00. The decrease could be caused by a number of factors, including, but not limited to, an increase in receivables or a reduction because of paying off liabilities. In this particular case the needs of the members were greater during the audited period causing additional payouts of $9,580,000.00. The audit also shows an expenditure for $1,797,000.00 for a 'needs processing program'. The needs processing program is a software program used to administer CCMS. These costs represent set up and operating costs.

H) The financial statements indicate that for the audited period CCM had purchased a reinsurance contract to cover excessive losses. The

CCMS members voted to terminate that reinsurance coverage in September of 2006.

17) Rosemary Bowna, Sherrie Erderberg and Jeremy Freed, all members of CCMS and all Illinois residents, testified on behalf of the Respondents in this matter as follows (see Transcript, pgs. 127-170):

A) The witnesses are all members of CCMS ranging in length of membership from six months to seven years;

B) When the witnesses joined CCMS they then understood and still believe that CCMS made no promise to them to pay their medical bills;

C) The witnesses all expressed their non-expert opinion that the CCMS program is not health insurance;

D) The witnesses believe, based upon instructions contained in the Bible, specifically Galatians 6:2, that Christians are required to shared each other burdens;

18) Robert Baldwin, a Respondent in this matter and the President of CCM testified on behalf of all of the Respondents as follows: (see Transcript, pgs. 170-275):

A) He is a graduate of Stetson University in Florida, has an MB from Rollins College, also in Florida. He has worked for CCM for three years and prior to that worked for a bank and for the financial division of semiconductor business. He is responsible for the entire CCM operation;

B) CCM is a 501 (c)(3) not-for-profit Florida corporation that manages several different programs, one of which is CCMS, another is called Christian Disability Sharing, and a third is a wellness program known as Restore. CCM has an office in Illinois with 35 employees which receive members' medical bills, reviews CCMS guidelines, and makes a determination if the bills are eligible for payment;

C) He believes that CCMS is a program consisting of like-minded Christians who come together to share in each other's medical bills, and by doing so are fulfilling the law of Christ as explained in Galatians, Chapter 6, Verse 2. CCMS was formalized as a ministry of CCM in 1993. CCM was in turn a ministry of the American Evangelistic Association (AEA). In December of 2006, the board elected to move CCMS and CCM under the umbrella of American Evangelistic Association International (AEAI) and disassociated themselves from the AEA. The organization is now operating under one name, the Christian Care Ministry Inc. (CCM);

D) Upon being contacted by a potential member, CCMS sends an information packet containing information about the program and an application for membership (Respondents Exhibit # 2). The information packet contains several representations that CCMS is not insurance and that there is no guarantee or promise that a member's medical bills will be paid. Once an individual becomes a member another guidelines packet (Respondent Exhibit # 4) is sent to the member which includes a CCMS membership card and a need reporting form. The need reporting form allows the member to submit a medical bill for sharing. Members are not required to participate in the program for certain distinct periods of time. Members are not dropped at the end of a time period. As of the end

of December 2006, there is no requirement for an annual membership fee;

E) The membership shares (money contributions) are placed in a lock box at Sun Trust. Sun Trust is a U.S. bank based in Atlanta, which maintains branches in Florida. Twenty five percent of the share dollars are "stripped away" from the lock box and are moved into a different account at the same bank under the control of CCM. These funds are used for operating expenses. The remaining 75% of the share dollars are deposited into one of approximately 18,000 sub-accounts in a Sun Trust bank account under the control of the CCM Trust. Each CCMS member has their own specific sub-account. When a need is approved by CCMS employees, CCMS computer program software, on a first come first serve basis, applies the share dollars to the need and payment is sent to the provider;

F) The stop loss insurance policy that was covering a portion of some of the member's medical expenses was cancelled effective 9/30/06. As soon as CCM receives approval from its 501(c)(3) counsel in Washington, D.C., it will move the Trust in its entirely to Florida;

G) CCMS guidelines are set by member ballot, after a ballot initiative has been approved by a steering committee. The committee consists of a cross-section of the membership.

19) On Cross-examination Witness Baldwin testified as follows:

A) He is the President of CCM, CCM's Vice President of Operation is Jim Gillespie, and Kevin Camili is the Chief Financial Officer. He was the CCM Chief Operating Officer prior to being its President and he is familiar with all aspects of the organization's operations.

B) CCMS Guideline changes often start with suggestions from members; a 17 member steering committee reviews the suggestion and determines if the suggestion should be referred to the CCMS Board. Recommendations may also be made by CCMS management, these recommendations also being referred initially to the steering committee. The Board then causes the idea to be placed on a ballot measure to be voted on by the entire membership;

C) CCM purchased most of the assets of a Third Party Administrator (CBA). This TPA had already contracted with Beech Street, a Preferred Provider Organization (PPO) (see Division Exhibit # 23);

D) Up to July or August 2006, CCM employed individuals who were compensated based upon securing CCMS membership renewals. Those employees are now salaried employees;

E) Various CCM management personnel have been paid bonuses in the past;

F) CCM has created its own medical interview software package to be used in determining a prospective applicant's suitability for the program. The spouse of a CCM board member was, until January 1, 2006, in charge of the nurses conducting the interviews regarding applicant suitability. She currently is employed as a nurse interviewer;

G) While the CCMS guidelines recognize the concept of pre-existing conditions and prospective members are denied entry into the program based on those pre-existing conditions, he has no idea about how those guidelines were developed;

H) CCM Trust maintains additional bank accounts in Wisconsin and Pennsylvania for the purpose of distributing funds to its members because of Stipulated Consent Orders entered into by CCM in those States with State insurance regulators;

I) The trust was originally set up in the Bahamas as a tax avoidance device specifically designed to avoid paying premium taxes on the CCM stop loss policy. The stop loss policy is no longer in effect and the Trust will be moved to Florida when CCM counsel completes his work on that issue;

J) CCMS members are terminated from the program if they do not pay their monthly share for a consecutive two month period.

20) Frederick John Jarosz, a retired executive from various insurance and financial industry jobs, testified on behalf of the Respondents in this matter as follows:

A) He was last employed as an Executive Vice President and Chief Marketing Officer with Horace Mann Insurance Company; prior to that as CEO with Western Traveler's Life Insurance Company, and before that as Chairman of Putnam Financial Services (see Respondents Exhibit # 7). Based upon the witness's long employment in the insurance field, the Hearing Officer allowed the witness to express opinions regarding various conclusions of law at issue in this matter;

B) In his opinion the CCMS program may be a contract, but is not an insurance contract. He based his opinion on his understanding of the CCMS guidelines. The members are not insureds because they

voluntarily enter into the program with no guarantees that "their own situation might get paid." Further, the CCMS program is not a specified period of time, there is no end date of a member's participation in the program. He also believes that, as the CCMS program is designed, CCMS has assumed no risk.

21) Capitol Reporting Service Inc., recorded the testimony taken in this matter and charged the Division $1,737.50 for the court reporter's attendance and a transcript of the proceeding (Hearing Officer Exhibit # 13).

22) On May 9, 2007, the Respondents filed with the Hearing Officer a Post-Hearing Motion entitled Respondents' Motion and Argument for Recusal, hereby entered into the Record as Hearing Officer Exhibit # 14. On May 17, 2007, the Division filed a Response to the Respondents' Motion and Argument for Recusal, hereby entered into the Record as Hearing Officer Exhibit # 18. The Hearing Officer has no authority under the Illinois Insurance Code, the Division's Hearing Regulation, or the Illinois Administrative Procedure Act (IAPA) (5 ILCS 100/10-5 et. seq.) to rule on this Motion. As such, the Parties' arguments in support of and in opposition to the Motion will not be discussed in this Report, nor will the Hearing Officer rule on the Motion.

23) Both the Respondents and the Division filed Post Hearing Briefs in this matter, hereby entered into the Record as Hearing Officer Exhibits # 15 and # 16 respectively.

24) On May 11, 2007, the Respondents' filed with the Hearing Officer a Motion entitled Respondents' Objection to a Matter Not Judicially Noticed Before or During the Hearing and Objection to a Judgment Not Presented During the Hearing, hereby entered into the Record in this matter as Hearing Officer Exhibit # 17). On May 17, 2007, the Division filed a Response to the

Respondents' Objection to a Matter Not Judicially Noticed, hereby entered into the Record as Hearing Officer Exhibit # 18.

DISCUSSION AND ADDITIONAL FINDINGS OF FACT

On March 19, 2007 the Director of Insurance issued an Order to Cease and Desist, pursuant to Section 401.1 of the Illinois Insurance Code (215 ILCS 5/401.1) ordering the Respondents in this matter to cease and desist any and all practices, as additionally described in the Order, involving the Respondents which purport to provide insurance benefits to the residents of the State of Illinois (see Hearing Officer Exhibit # 2). The purpose of the Hearing was to allow, as is required by Section 401.1 of the Code, the Respondents an opportunity to be heard regarding the allegations made in the Order, and to prepare a Record of the proceeding for the Director's review.

The issue to be determined is if whether the Director's Order to Cease and Desist should be made permanent against the Respondents, or rather should the Order be withdrawn. In order to make this decision it is necessary to determine whether the Respondents are offering insurance benefits in this State. As the Record in this matter clearly reflects, determining whether the Respondents are offering insurance through their CCMS program is not a simple task.

Prior to beginning the discussion of the insurance issues, there are several matters raised by the Respondents in the form of asserted Affirmative Defenses and Motions made during and after the Hearing that must be discussed. First, the Respondent, at the end of the Division's Case in Chief, made a Motion for Directed Verdict. The Hearing Officer declined to rule on the Motion at the time indicating that the Motion would be dealt with in this Report. Upon review of the Division's case, the Hearing Officer concludes that it provides sufficient evidence to support the initial issuance by the Director of a Cease and Desist Order in this matter and therefore the Respondents' Motion for Directed Verdict is denied.

Second, prior to the start of the proceeding the Respondents filed an Answer and Affirmative Defenses (see Hearing Officer Exhibit # 12). In this document the Respondents provided their answer to the allegation that they were providing insurance benefits to CCMS members, as well as, put forth the following Affirmative Defenses. The Respondents argue that the Director's Cease and Desist Order:

- Is an infringement on the Respondents' religious freedom in violation of Article 1, Section 3 of the Illinois Constitution;
- Is a substantial burden on the free exercise of religion in violation of the Illinois Freedom Restoration Act (775 ILCS 35/1 et. seq.);
- Is an infringement on the Respondents' religious freedom in violation of the United States Constitution; and
- Is an arbitrary and capricious act, an abuse of the Director's discretion and is an act beyond the Director's statutory authority.

The Hearing Officer, during the course of the Hearing, allowed the Respondents to establish facts and submit argument regarding its Affirmative Defenses. However, the Hearing Officer has no authority under the Director's appointment as Hearing Officer; the Division's Hearing Procedures Regulation, the Illinois Insurance Code, or the Illinois Administrative Procedure Act (IAPA), to offer Conclusions of Law to the Director regarding the Respondents' Affirmative Defenses. Therefore, this Report shall provide no such offer and the Respondent will have to pursue those arguments in the circuit courts of this State.

Third, the Respondents filed two Post-Hearing Motions in this case; a Respondents' Motion and Argument for Recusal and a Respondents' Objection to a Matter Not Judicially Noticed Before or During the Hearing and an Objection to a Judgment Not Presented During the Hearing (see Hearing Officer Exhibits # 14

and # 17). The Division filed Responses to both Motions (see Hearing Officer Exhibits # 18 and # 19).

In their Motion for Recusal the Respondents argue that the Director has exhibited bias towards the Respondents and request that the Director recuse himself from making a decision regarding the permanency of the Order to Cease and Desist. The Respondents argue that the Director has exhibited bias by making certain remarks to an Illinois State Representative regarding the Respondents prior to the Hearing (see Respondents Exhibit # 1). The Respondents further point to an Order issued by the Director rescinding an Order entered by the Hearing Officer granting the Respondents' Request for Discovery and Motion for Continuance (see Hearing Officer Exhibit # 6).

While the Hearing Officer concludes that he has no ability, pursuant to aforementioned authorities, to rule on the Respondents' Motion to Recuse and that task must be left to the Director, the Hearing Officer would offer the following observations. The Respondent and the Division were not denied discovery in this matter. First, while it is true that the Hearing Officer's Order allowing discovery was rescinded by the Director's April 13 Order, and that Order made no provision for the parties to engage in discovery, the Record indicates that the Parties did so anyway, of their own accord, absent a formal order. The Record in this matter reflects discussions by the Parties about their exchange of documents prior to the Hearing. In fact, at one point, Counsel for the Respondents remarked, regarding the admissibility of Division Exhibit # 26, that he didn't recall getting that particular Exhibit from the Division prior to the Hearing, but if the Division's Counsel said that it was provided, then he believed that it was (see Transcript pg. 26).

Also, in an administrative proceeding the Parties have no right to discovery, either established by statute or Illinois case law. The Parties only right to discovery is established by the Division's Hearing Rule (50 Ill. Adm. Code 2402). As such

either the Hearing Officer, or the Director, could have prior to the Hearing determined that there would be no discovery in this proceeding.

Regarding the Respondents' belief that the Director exhibited bias by making certain remarks to an elected official prior to the start of this proceeding, the Hearing Officer offers the following. The Director of Insurance has the statutorily mandated duty to enforce all of the insurance laws of this State, pursuant to Section 401 of the Illinois Insurance Code (215 ILCS 5/401). This, of course, includes his duty to investigate and bring forth allegations of violations of the Insurance Code in order to protect the citizens of the State from those who would violate said laws. The same body of law then requires the Director, after the investigation is complete and after a hearing is held to establish the facts of a particular situation, to "change hats," if you will, become an adjudicator, and make a decision regarding the issues of a case in which he originally made the decision to allege violations of the Code. That is the nature of administrative regulation. Given the above, it is not surprising that the Director, prior to the preparation of the Record in this matter, may have made the comments recorded in Respondents Exhibit # 1. In the Hearing Officer's opinion, the Director's statements made during the investigation phase of this matter are not unusual and do not establish bias pursuant to the rule established in Sangirardi v. Village of Stickney, 342 Ill. App. 3rd 1 (1st Dist. 2003).

Fourth, in it's Post-Hearing Brief (see Hearing Officer Exhibit # 16), the Division included a reference to a Proposed Order, dated May 2, 2007, in Case # 07 CH 324, Bowman v. McRaith, in the Sangamon County, Illinois Circuit Court, and a Judgment Order, dated April 24, 2007, in Case # DBV-2006-109, Rowden v. Christian Care Ministry, from the Lewis & Clark County District Court in Montana. The Division asks that the Hearing Officer take judicial notice of the Sangamon Court Order. The Respondents argue that such request is prohibited by the Illinois Administrative Procedure Act, Section 10-40. This Section provides that notice, in administrative proceedings, may be taken of matters of which the

Illinois circuit courts may take judicial notice, Parties shall be notified, either before or during the hearing, of material noticed. Respondents argue that the Division did not ask, either before or during the Hearing, that the Hearing Officer take judicial notice of the Sangamon County Order, and further, because the Hearing Officer did not allow Response Briefs to be filed in this matter, the Respondents had no opportunity to object to the inclusion of the Sangamon County Order in the Record. The Hearing Officer agrees. Based on Section 10-40 of the IAPA, the Hearing Officer finds that the Division's request that the Hearing Officer take Notice of the Sangamon County Order should be denied. The Order will remain a part of the Record in this matter but will not be used by the Hearing Officer in his deliberations.

Regarding the Division's reference to the Montana Order, while that Order itself was not specifically offered at the Hearing, various other filings in the case were entered into the Record over the Respondents' Objection. The Division, in it's Response, indicates that it did not have possession of the document, or even knew of its existence until after the Hearing in this matter was concluded. The Hearing Officer finds that the Division did not violate Section 10-40 of the IAPA in using this document in it's Brief, since it could not have asked for the document to be noticed before or during the Hearing. Further, the Hearing Officer concludes that since pleadings in the case have already been entered into the Record, it is within the Hearing Officer's authority to allow into the Record, and take notice of the judge's decision in the case. The Respondents' objection and request to exclude the Montana Order are denied.

At this point, the Hearing Officer shall discuss the insurance issues raised in the matter. The Division's position is that the Respondents are conducting an insurance business in Illinois without the requisite authority to do so. The Respondents argue that the Record in this matter contains no evidence that the Respondents are in violation of Section 121 of the Illinois Insurance Code (215 ILCS 5/121). Section 121 makes it unlawful for any company to transact an

insurance business in this State without first obtaining a certificate of authority from the Director. While neither party provided direct evidence regarding whether the Respondents currently, do or do not, hold a certificate of authority from the Director of Insurance to conduct an insurance business, the Respondents did not list such fact as one of their Affirmative Defenses or mention such fact in their presentation of evidence in this matter. The Parties, apparently, assumed that this information was in the Record, and proceeded with their cases.

The Hearing Officer has, therefore, made a search of the Division's licensing business records and finds that none of the Respondents hold a certificate of authority to act as an insurance company in Illinois.

Whether the CCMS program is in the business of insurance has been the subject of much debate in the courts and among insurance regulators in a number of States (see Division Exhibits # 1 thru # 7), including at least one case in the circuit courts in Illinois. Regulators have taken action ranging from the issuance of Cease and Desist Orders similar to the one issued in Illinois, to entering Stipulated Agreed Orders with the Respondents. The Agreed Orders required the Respondents to prominently display disclaimers in their materials indicating that the CCMS program is not insurance and potential members should strongly consider purchasing an insurance policy with an insurance company licensed in that State. In other Agreed Orders regulators required CCMS to place monies collected from the members in their States in bank accounts located in those States.

State courts have struggled with the CCMS concept and have come to different conclusions; a large judgment being entered against CCMS in Montana, while a court in Kentucky ruled that the program was not insurance pursuant to Kentucky law. The judge in the Lake County, Illinois case made relevant rulings regarding CCMS which will be discussed later in this report. That case, however, was ultimately settled via mediation prior to a final adjudication of the issues.

Because insurance is regulated in the United States on a state by state basis, insurance laws differ significantly from jurisdiction to jurisdiction. Therefore, the Hearing Officer finds that the Division's evidence of various decisions and orders from courts and regulators is of limited assistance in determining whether the CCMS program is the business of insurance in Illinois. These decisions, however, are relevant to the issue and provide the basis for a revealing look at how the Respondents respond to regulatory and judicial authorities, and how the CCMS program has evolved in Illinois.

Professor Robert E. Keeton of Harvard University and Professor Alan I. Widiss of the University of Iowa, in Insurance Law; A Guide to Fundamental Principals, Legal Doctrines and Commercial Practices (student ed., 1998) discuss the problem of determining what constitutes insurance. The Hearing Officer believes that their discussion is quite helpful in the providing a logical approach to the determinations required in this case.

The professors state "controversies about what is insurance arise most frequently as a consequence of disputes over the applicability of regulatory measures promulgated in Statutory provisions or administrative rulings. Although it is generally agreed that two of the principal characteristics of insurance are transferring and distributing risk, demonstrating that a contractual agreement has these characteristics usually has not been sufficient to resolve a dispute about the nature of a particular transaction." Warranties and guaranteed maintenance contracts are examples of agreements that exhibit transference and distribution of risk that are not generally considered to be insurance contracts.

The nature and scope of an insurance regulation is not always clearly specified and therefore the effects of both legislative and administrative action have been the subject of a substantial number of disputes. When an issue arises in regard to the nature or scope of insurance regulation, it is essential to carefully consider the

applicable insurance statutes, administrative provisions and judicial decisions (emphasis added). Especially among the body of statutory and administrative insurance regulatory measurers, some apply to all or nearly all types of insurance transactions, while others apply to a relative few. Caution should also be practiced in regard to the application or interpretation of judicial decisions. There is always a temptation to employ any available precedents when an issue involves basic issues-such as what constitutes an insurance transaction or conducting an insurance business-about the meaning of a statute or administrative rule. However, even when judicial precedent are urged only as analogical support for a proposition, the possible reasons for distinguishing decisions involving another type of insurance should be fully explored (emphasis added). Furthermore, the perspective from which judicial precedents interpreting regulatory measures are appraised should always include a consideration of whether the definition of insurance implicit in the scope of one insurance regulatory measure is or is not appropriate for deciding the scope of another doctrine. In many states, discerning the scope or reach of the regulatory statutes is complicated by the fact that the legislative provisions do not set forth any definition of insurance to guide the courts and administrative agencies."

Illinois insurance statutes do not define the term insurance. Section 121 of the Illinois Insurance Code states, in part, as follows:

"Transacting business without certificate of authority prohibited.

(1) It shall be unlawful for an company to enter into a contract of insurance as an insurer or to transact insurance business in this State, without a certificate of authority from the Director; provided that this subsection shall not apply to contracts procured by agents under the authority of Section 445 [215 ILCS 5/445], nor to contracts of reinsurance.

(2) The following acts, if performed in this State, shall be included among those deemed to constitute transacting insurance business in this State:

(a) maintaining an agency or office where contracts are executed which are or purport to be contracts of insurance with citizens of this or any other State;

(b) maintaining files or records of contracts of insurance; or

(c) receiving payment of premiums for contracts of insurance. . . "

Section 121-3 of the Insurance Code (215 ILCS 5/121-3) provides as follows:

"Transaction of insurance business defined. Any of the following acts in this State, effected by mail or otherwise by or on behalf of an unauthorized insurer, constitutes the transaction of an insurance business in this States:

(a) The making of or proposing to make, as an insurer, an insurance contract;

(b) The making of or proposing to make, as guarantor or surety, any contract of guaranty or suretyship as a vocation and not merely incidental to any other legitimate business or activity of the guarantor or surety;

(c) The taking or receiving of any application for insurance;

(d) The receiving or collection of any premium, commission, membership fees, assessments, dues or other consideration for any insurance or any part thereof;

(e) The issuance of delivery of contracts of insurance to residents of this State or to persons authorized to do business in this State;

(f) Directly or indirectly acting as an agent for or otherwise representing or aiding on behalf of another any person or insurer in the solicitation, negotiation, procurement or

effectuation of insurance or renewals thereof or in the dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, a fixing of rates or investigation or adjustment of claims or losses or in the transaction of matters subsequent to effectuation of the contract and arising out of that contract, or in any other manner representing or assisting a person or insurer in the transaction of insurance with respect to subjects of insurance resident, located or to be performed in this State. This paragraph does not prohibit full-time salaried employees of a corporate insured from acting in the capacity of an insurance manager or buyer in placing insurance in behalf of that employer;

(g) The transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of this Act;

(h) The transacting or proposing to transact any insurance business in substance equivalent to any of the foregoing in a manner designated to evade this Act;"

Clearly, the Illinois General Assembly has not provided a dictionary type definition of insurance, preferring to provide descriptions of activities that constitute the transaction of insurance business. A review of the evidence of how the CCMS program works and a comparison of that evidence with the descriptions in Section 121-3 follows. During the Hearing and in their Brief the Respondents made much of their contention that the CCMS program has undergone changes, that much of the Division's evidence consists of the 'old' CCMS program, and that the Director should be limited to what the program looked like on March 19, 2007, when he issued his Cease and Desist Order. While the Hearing Officer does not necessarily agree with the limits that the Respondents suggest, we will examine the evidence in the Record most favorable to the Respondents,

namely, the Respondents' exhibits and witness testimony, in making the aforementioned comparison.

The Respondents describe their program as follows (at the end of each description is a comparison of that activity to Sections 121 or 121-3 of the Illinois Insurance Code):

A) CCMS is a program where like-minded Christians come together to share in each others medical bills (see Transcript p. 173);

Section 121-3(g) states that the business of insurance is "the transaction of any kind of insurance business specifically recognized as transacting an insurance business within the meaning of this Act." Section 4 of the Illinois Insurance Code, Classes of Insurance (215 ILCS 5/4) states, in part, as follows: "Insurance and insurance business shall be classified as follows: Class 1. Life, Accident and health . . .

(b) Accident and Health. Insurance against bodily injury, dismemberment or death by accident and disablement resulting from sickness or old age and every insurance appertaining thereto, including stop loss insurance."

B) CCMS maintains an office in the Rock Fall/Sterling, Illinois area employing 35 individuals whose tasks include the processing of medical bills, the reviewing of the CCMS guidelines, imaging the provider bills, comparing the bills and the guidelines in order to determine if the bills meet the guidelines and therefore should be paid (see Transcript p. 172).

Section 121 of the Insurance Code provides that "the following acts, if performed in this State, shall be included among those deemed to constitute transacting insurance business in this State.

a) maintaining an agency or office where contracts are executed which are or purport to be contracts of insurance with citizens of this State or any other State;

b) maintaining files or records of contracts of insurance; . . . "

C) CCM purchased the assets and hired some of the employees of CBA, a Third Party Administrator (TPA) to process the medical bills on behalf of CCM and CCMS (see Transcript, pgs. 176-177).

Section 121-3(f) of the Insurance Code provides, in part, as follows:

"f) Directly or indirectly acting as an agent for or otherwise representing or aiding on behalf of another any person or insurer in the solicitation, negotiation, procurement or effectuation of insurance or renewals thereof or in the dissemination of information as to coverage or rates, or forwarding of applications, or delivery of policies or contracts, or inspection of risks, a fixing of rates or investigation or adjustment of claims or losses or in the transaction of matters subsequent to effectuation of the contract and arising out of that contract, or in any other manner representing or assisting a person or insurer in the transaction of insurance with respect to subjects of insurance resident, located or to be performed in this State. This paragraph does not prohibit full-time salaried employees of a corporate insured from acting in the capacity of an insurance manager or buyer in placing insurance in behalf of that employer (emphasis added).

D) CCM and CCMS advertise their program on Christian radio broadcasts and print media and on the CCM web site (T. p.178)

See Section 121-3(f) language above re the solicitation of insurance and the dissemination of information is to coverage or rates.

E) Upon being contacted by a prospective member, CCM and CCMS send out a package of information called "Flight One" which contain the guidelines regarding the program (see Respondents' Exhibit # 2). Flight One contains a cover letter signed by Respondent Baldwin, describing the program, the requirement that members send to CCM and CCMS a monthly "share" (premium), and reference to other restrictions (pre-existing conditions exclusions). Flight One also contains the CCMS Guidelines booklet which in turn, contains a Membership Form (Application) to become a member. And finally, Flight One contains the Disclaimer, mentioned earlier in this Report, from the States of Kentucky, Maryland, Pennsylvania and Wisconsin (see Transcript pgs. 178-185).

Sections 121-3(c), (g) and (f) of the Insurance Code provide that the business of insurance includes the receiving or collecting of premiums, commissions, membership fees, assessments, dues or other consideration, as well as, the solicitation, negotiation, or procurement of insurance and the taking of an application for insurance.

F) After a prospective member submits the application contained in Respondents Exhibit # 2, and if the application is accepted by CCM and CCMS (underwriting), the then newly accepted member

receives a "Welcome Aboard Kit" (Respondents Exhibit # 4). The Kit contains another set of guidelines, a Need Reporting Form (claim form) whereby the member can report a medical expense for "sharing" by the other members, a membership card, a prescription discount card, description of the CCMS 250 and 911 programs, which establish $250 and $911 member responsibility (deductibles) for their medical expenses, and descriptions of other CCM and CCMS programs, such as Christian Disability Sharing (see Transcript, pgs. 186-190).

See Section 121-3(f) description of the transaction of an insurance business.

G) And finally Section 121-3(h) which provides that the transacting or proposing to transact any insurance in substance equivalent to any of the foregoing in a manner designed to evade this Act. Respondent Baldwin's testimony, as indicated below, includes several references to changes made in the CCMS program because of adverse court or regulatory rulings which, in the Hearing Officer's opinion, were clearly attempts to evade the unauthorized insurance statutes in Illinois and other jurisdictions (see bullet points below).

- In responding to his Counsel's questions regarding whether the CCMS membership was for a specified period of time, Respondent Baldwin stated; "No, there is not" Counsel asked; "Was there ever before?" Respondent replied; "There was a – I believe what was the judge in whatever county here (Illinois) pointed to the fact that at one point we had an annual membership fee of $150. I recall that members paid once a year, and the judge in the case pointed to that as evidence of some type of term (as an element of an insurance contract). But as of the end of December we no longer

have any requirement for an annual membership fee" (parentheticals added) (see Transcript p. 190).

- On Pages 203 -204 of the Transcript, the following questions and answers were exchanged between Counsel and the Respondent:

Q. And the fact that you once had a stop loss policy, wasn't that critical in the Lake County case which I referred to earlier?

A. I believe I remember reading about it in the case.

Q. Do you still have the judge's decision - -

A. I do.

Q. - - before you. In that order, Judge Margaret Mullen on page 10, Mr. Baldwin, about oh, the additionally, would you mind reading that into the record?

A. Sure. "Additionally, reference is made to the reimbursement of claims by a stop loss insurance policy which covers eligible needs from $50,000 to a million dollars per policy year." Stop there or keep going?

Q. Keep going.

A. "Medi-Share's promise to provide stop loss insurance to cover its exposure under its agreement with the plaintiff is certainly the provision of insurance."

Q. And the last sentence?

A. "For these reasons the fourth prong of the Griffin test is met."

Q. But again, as you've testified, that stop loss policy's no longer in existence?

A. That's correct.

Q. As of which date again?

A. September 30, 2006.

- On Page 231 of the Transcript, the following exchange took place between the Counsel for the Division and the Respondent.

Q. Okay. Now when you talked about people signing up, you mentioned that generally they call the office or go on the web cite, but you also have a group of people that get renewal rated for, and pardon me, selling a product?

A. No, we don't, not any longer.

Q. Okay. And when did that change?

A. July of 2006. Maybe August 1st, it was either July or August of 2006.

Q. And how are those people compensated now?

A. They're employees that are on salary.

Q. Okay.

A. There's about six of that group that are still with us.

Each of the exchanges above indicate changes that were made in the CCMS program by the Respondents which, in the Hearing Officer's opinion, are not only indicative of the Respondents' understanding that they offered an insurance product but also indicative of the Respondents' attempts to evade the Illinois Unauthorized Insurance Article (215 ILCS 5/121 et. seq.).

In light of the above statutory analysis Hearing Officer finds that the Respondents' activities regarding the CCMS program are the transaction of an insurance business in the State of Illinois, as that term is used in Sections 121 and 121-3 of the Illinois Insurance Code.

ILLINOIS CASES

On September 6, 2005, in the Circuit Court of the Nineteenth Judicial Circuit, Lake County, Illinois, Georgeanna Guritz filed a Verified Complaint at Law against CCMS in Case # 5 L 740, Guritz v. Christian Care Medi-Share, alleging in Count 1, a breach of contract by CCMS and in Count II, a vexatious and

unreasonable denial of an insurance claim by CCMS (see Divisions Exhibits # 1 and # 1A). In an Order dated May 3, 2006 regarding a CCMS Motion to Dismiss Count II of the Complaint, Judge Margaret J. Mullen, stated that the leading Illinois in case (on the definition of insurance) is Griffin System Inc., v. Washburn, 153 Ill. App. 3d 113 (1st Dist. 1987). Judge Mullen quoted the characterization by the Griffin court of what constitutes insurance as follows:

> "Insurance can be characterized as involving: (1) a contract or agreement between an insurer and an insured which exists for a specific period of time; (2) an insurable interest possessed by the insured; (3) consideration in the form of a premium paid by the insured to the insurer; and (4) the assumption of risk by the insurer whereby the insurer agrees to indemnify the insured for potential pecuniary loss to the insured's property resulting from certain specified perils."

Because the parties to the Guritz case settled their law suit via mediation, there was never a final adjudication by Judge Mullen on the insurance issues raised in the case. However, it is quite clear from the analysis contained in her Order on Defendant's Motion to Dismiss that she believed that the CCMS program was insurance as that term was discussed in Griffin.

As indicated early in this Report Respondent Baldwin testified that a number of changes have been made in the CCMS program. Judge Mullen stated that in the Guritz case the CCMS guidelines bear the indicia of an insurance contract and met all four prongs of the test enunciated in Griffin. Prong one was met by the fact that the program was renewed annually. Prong two was met because the CCMS membership has an insurable interest in their health care. The prong three requirement of consideration was met by the monthly shares paid by the membership to CCMS. And the fourth prong, shifting of risk, was met because the

contract clearly trades a premium for shared risk of potential losses among many members. Judge Mullen also, in the prong four analysis, referred to the CCMS stop loss coverage insurance policy, which provided additional coverage for CCMS members, as an indication of a shifting of risk. In her conclusion regarding the Motion to Dismiss Judge Mullen stated:

> "In conclusion, although the Medi-Share Guidelines deny it offers insurance, the court finds the complaint, if proved, would state a cause of action for the vexatious denial of an insurance claim. Therefore, the motion to dismiss pursuant to Section 2-615 of the Code of Civil Procedure is denied."

The Hearing Officer finds that Judge Mullen, based on the fact situation presented to her, concluded that CCM and CCMS were transacting insurance business in the State of Illinois.

THE GRIFFIN AND HOMEWARD BOUND CASES

The Respondents' main argument on the insurance issues in this case is that the Respondents' activities in Illinois are not the business of insurance. The Respondents argue that if it is determined that CCM and CCMS have not engaged in the transaction of an insurance business, the Respondents have not violated Sections 121 and 121-3 of the Insurance Code. The Respondents mostly rely on Griffin Systems, Inc. V. Washburn, 153 Ill. App. 3d 113 (1st Dist. 1987) and Homeward Bound Services, Inc., v. Illinois Department of Insurance, 365 Ill. App. 3d 267 (3rd Dist. 2006). The Respondents did not offer evidence or argument regarding a statutory analysis of the definition of insurance.

Judge Mullen, in her aforementioned Order in the Guritz case, provided an apt description of the Griffin and Homeward Bound cases, Judge Mullen stated:

"The leading Illinois case is Griffin Systems, Inc. v. Washburn. (cite omitted by Hearing Officer). In that case, Griffin Systems appealed the issuance of a cease and desist order by the Department of Insurance. The Company marketed a plan it described as a mechanical service contract. Under the plan, Griffin agreed to repair or replace certain automobile parts covered by the plan should those parts break down or fail during the coverage period. The plan provided for a $25 deductible per part. The customer could select from four different plans, which differed in length of time and the number of parts covered. The policies also contained exclusions, limitations, and conditions." (The Griffin Court then announced its four part test quoted earlier in this Report) (parentheticals added). The court found that the "Vehicle Protection Plan" was a contract of insurance, rejecting Griffin's argument that it was a service contract. The court noted that the policy bore all the "indicia" of a contract of insurance. First, the "Vehicle Protection Plan" was clearly an agreement between Griffin and a customer which lasted for a specified period of time. Second, there was an insurable interest involved, namely, the mechanical parts of the customer's vehicle which were covered by the plan. Third, under the plan, the customer was obligated to pay a premium in return for Griffin's promise to reimburse the customer for the repair or replacement of certain automobile parts. Fourth, Griffin agreed to indemnify the customer for a potential future loss; specifically, the costs involved in the repair or replacement of certain automobile parts. The court concluded that the essence of the plan was to indemnify the customer, i.e., to reimburse the customer for a possible future loss to a specified piece of property caused by a specified peril, namely mechanical failure. Consequently, the plan constituted insurance. Griffin Systems Inc., 153 Ill. App. 2d at 116-117."

Judge Mullen further stated "recently, in a decision not yet final, the Third District Appellate Court considered whether an Assisted Living Service

> Agreement constituted insurance. In Homeward Bound Services, Inc. v. Illinois Department of Insurance, (cite omitted by the Hearing Officer) (parenthetical added) the Department issued a cease and desist order against Homeward Bound, which had been marketing what it described as a "PRE-NEED service contract." The contract was styled as an "Assisted Living Service Agreement" [hereinafter ALSA], and offered to provide the customer with in-home assistance for a specified period. The fee structure was based upon age and medical condition. Each ASLA contained a waiting period during which the customer could not receive services for pre-existing conditions. The waiting period varied in length, depending on the client's medical condition.

Applying the Griffin court's four-pronged definition of insurance, the court in Homeward Bound affirmed the administrative ruling. Noting that Homeward Bound's written materials stated its product was not insurance, the court observed:

> It is immaterial, or at least not controlling that the term "insurance" nowhere appears in the contract, the nature of which is to be determined; indeed, the fact that it states it is not an insurance policy is not conclusive, and a company may be found to be engaged in an insurance business even though it expressly disclaims any intention to sell insurance.... The nature of a contract as one of insurance depends upon its contents and the true character of the contract actually entered into or issued – that is, whether a contract is one of insurance is to be determined by a consideration of the real character of the promise or of the act to be performed, and by a consideration of the exact nature of the agreement in the light of the occurrence, contingency, or circumstances under which the performance becomes requisite, and not by what it is called."

The Respondents' contention in the case bar is that the Division has not met its burden of proof that any of the four prongs enunciated in Griffin have been met (see Respondents' Post-Hearing Brief, Hearing Officer Exhibit # 15 pgs. 8-14). The Division argues that the Record in this case demonstrates that the Respondents' activities in Illinois meets all four prongs of the Griffin case and the Respondent should therefore be held to be an unauthorized insurer under Illinois Law (see Division Post Hearing Brief, Hearing Officer Exhibit # 16 pgs.7-17).

Despite the Respondents' best attempts to alter the CCMS program after Judge Mullen's ruling in the Guritz case, the Hearing Officer agrees with the Division that the Respondents' activities in Illinois meet all four prongs of the Griffin test.

Prong one requires a contract or agreement between the parties. The relationship between CCM, CCMS and their membership is one that begins with an offer by CCM and CCMS, which when accepted by an applicant is followed by the payment of consideration by the applicant. The Respondents' attempt to avoid the contract requirement of the first prong by adjusting their agreement with their members to appear that the agreement, is not for a set period of time. Respondent Baldwin testified, however (Transcript p. 269), that members are terminated if they miss their monthly share payment for two months. The Hearing Officer believes that this ability by the Respondents' to unilaterally terminate their members for non-payment of premium sets a de factor time frame for the agreement and thus along with the offer, acceptance and payment of consideration, satisfies prong one.

Prong two requires that there be an insurable interest possessed by the insured. CCMS members have an insurable interest in the protection of their health. Prong two is satisfied.

Prong three requires consideration in the form of a premium paid by the insured to the insurer. CCMS members are required to pay monthly "shares" (premium payments) to CCM and CCMS in order to participate in the program. If the members do not pay, they are terminated from the program. Prong three is met.

Prong four requires an assumption of risk by the insurer. The Respondents essentially base their entire argument in this matter on their belief that CCMS is not assuming any risk in their agreement with their members. CCM and CCMS promotional material, guideline booklets and applications all include, in numerous and conspicuous locations, information indicating that CCMS is not insurance and that CCM and CCMS are not agreeing to pay the members' medical bills.

The Hearing Officer disagrees with the Respondents' contentions. First, the Homeward Bound decision clearly states that the fact that the term 'insurance' appears nowhere in the agreement, or that the agreement states that it is not an insurance policy is not controlling or conclusive. Rather the nature of the contract will be determined by a consideration of the real character of the agreement. The Hearing Officer concludes that the Respondents' repeated statements that CCMS is not an insurance contract are meaningless. The Record in this case clearly demonstrates that the true nature of the agreement is that it is an health insurance contract. Secondly, the Hearing Officer believes that CCM and CCMS have assumed the risk of paying their members medical bills. The Hearing Officer is persuaded by the Division's arguments highlighting the many ways in which CCM and CCMS manage or attempt to reduce the risk of money having to be paid out of their Trust bank accounts for medical bills. The Respondents underwrite risks that will be accepted during the application process based upon their view of a healthy Christian life style. The Respondents contract with TPA's to efficiently handle administration of their program. The Respondents contract with claim processing providers to assist with claim payments. The Respondents contract with preferred provider organizations to reduce health care costs. The Respondents recognize and utilize pre-existing conditions (except for their own management, see Division Exhibit # 26) to reduce liability to CCMS. In short, CCM and CCMS take the exact same steps that licensed health insurance companies take to minimize their liabilities under their contracts. The only real difference between CCMS and an insurance company is that CCM has convinced well meaning, but naive individuals that it is acceptable, in the name of religious fellowship, for CCM and CCMS to take their money to pay a shared risk pool's medical expenses, until CCM and CCMS unilaterally decide to no longer pay those shared risks, possibly even their own.

And finally, the Hearing Officer is convinced that Griffin's fourth prong is met by the Judgment entered against CCM and CCMS by the Montana courts indicating that the Respondents were in breach of their contract in the amount of $75,000.00 (total judgment in the amount of approximately $875,000.00). The pleadings in the Montana case

entered into the Record in this matter (Division Exhibit # 3) indicate a fact pattern in Montana that is substantially similar to CCMS activities in Illinois. In order to find a contract breach and award damages CCMS must necessarily have assumed, or had assigned to it by the Court, risk under the contract. The Hearing Officer finds that the evidence presented in this matter indicates that the Respondents have conducted an insurance business in Illinois, without authority to do so, as that term is defined in the Griffin and Homeward Bound cases.

Should the Director of Insurance determine that the facts of this case indicate that the four prongs of Griffin have not been met, the Hearing Officer concludes that it should be held that the Respondents are nonetheless engaged in the unlawful transaction of insurance business in Illinois for the following reasons.

First, the Respondents, as discussed earlier, are transacting an insurance business in Illinois as that term is described in Sections 121 and 121-3 of the Illinois Insurance Code. The Respondents' activities also meet the "transacting insurance business in substance equivalent to any of the foregoing in a manner designed to evade this Act" requirement contained in Section 121-3(h) of the Code. This statutory framework, as designed by the Illinois General Assembly, was not discussed or considered by the Griffin court. As urged by Professors Keeton and Widiss, the Director should give great weight to the intent of the General Assembly in enacting these statutes and view them as an alternative to the Griffin test in determining what constitutes the transaction of insurance business.

Second, the Griffin Court did not intend its four prong test to be mandatorily applied to every fact situation involving an issue of what constitutes insurance. In announcing its four prong test the Court stated: "Thus it appears that "insurance" can be characterized as involving: "(four part test)" (emphasis and parenthetical added). By using the word "can" the Court indicates, in the Hearing Officer's opinion, that the test is a guideline that one is able to use to make the determination, if the facts so warrant. The Hearing Officer agrees that the test can functionally be used to characterize insurance in certain

circumstances, but the Court, nowhere in it's decision, indicates that use of the four prong test is mandatory or must be used exclusively in making the determination;

Third, the Griffin case can and should be, again as urged by Keeton and Widiss, distinguished from the case at bar. In Griffin the issue was whether the product Griffin sold was a service contract or the warranty, as opposed to an insurance contract. The product was an agreement between Griffin and the purchaser to repair or replace certain automobile parts. While not attempting to denigrate the importance of service contracts, warranties, or insurance contracts that offer similar benefits to consumers or the industries that sell the products, none of those agreements rise to the complex level of, or daily importance to the lives of their purchasers as does a health insurance contract. Because of differences in the nature of the risks covered, the indices of whether an agreement is an insurance contract covering automobile parts or one covering an individual's health related needs do not coincide. As such, while the Griffin test provides useful guidance regarding certain types of insurance contracts, it was not meant or designed to be the ultimate controlling authority on the issue.

CONCLUSIONS OF LAW

Based upon the above-stated Findings of Fact and the entire Record in this matter the Hearing Officer offers the following Conclusions of Law to the Director of Insurance.

1) The Director of Insurance has jurisdiction over the subject matter and the parties to this proceeding pursuant to Sections 121, 121-3, 401, 402 and 403 of the Illinois Insurance Code (215 ILCS 5/121, 5/121-3, 5/401, 5/402 and 5/403).

2) The Respondents are transacting an unauthorized insurance business in the State of Illinois in violation of Section 121 of the Illinois Insurance Code.

3) The Director of Insurance properly and correctly issued his Cease and Desist Order in this matter pursuant to Section 401.1 of the Illinois Insurance Code (215 ILCS 5/401.1).

4) Respondent CCM should be assessed the costs of this proceeding in the amount of $1,737.50 pursuant to Section 408 of the Illinois Insurance Code (215 ILCS 5/408).

RECOMMENDATIONS

Based upon the above stated Findings of Fact, Conclusions of Law and the entire Record in this matter the Hearing Officer offers the following Recommendations to the Director of Insurance.

1) The Cease and Desist Order be made permanent; and

2) Respondent CCM be assessed the costs of this proceeding.

Respectfully submitted,

Date: 5-25-07

Timothy M. Cena
Hearing Officer